Off-Year Assessment

This Off-Year Assessment document is completed by Core Standardized Assessment assessors in a telephonic interview with the case manager/service worker (CM/SW). The assessment document is completed within an access database and provided to the CM/SW. The CM/SW will retain the completed assessment to fulfill the requirement of the annual assessment.

Background Information

Member Name: _____ (First Name) _____ (MI) _____ (Last Name) SID: _____ DOB: _____ (MM) / _____ (DD) / _____ (YYYY)

Service Type: ☐ AIDS ☐ BI ☐ CMH ☐ Elderly ☐ H&D ☐ ID ☐ PD CM/SW Name: _____ (First Name) _____ (Last Name)

Anniversary Date: _____ (MM) / _____ (DD) / _____ (YYYY) Assessment Date: _____ (MM) / _____ (DD) / _____ (YYYY)

Medical Conditions/Diagnoses

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

Risk Factors	Yes	No	Unknown	
	☐	☐	☐	Is the member in need of a primary healthcare provider?
	☐	☐	☐	Is the member in need of a dentist?
	☐	☐	☐	Is the member in need of a specialist?
	☐	☐	☐	Has the member had problems not taking or not receiving medications on time?
	☐	☐	☐	Have there been issues with medications not being re-evaluated timely?
	☐	☐	☐	Has the member had significant medication changes in the past year?
	☐	☐	☐	In the past year, has the member gone to an emergency room? If yes, how many times? If yes, why?

Notes:

↑ Improved ↓ Decreased Function ⇆ Stayed Same ✖ Not A Concern

Any risk factor marked 'Yes' must be addressed in the member's Crisis Intervention Plan

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Activities of Daily Living

	↑	↓	⇆	✕
Eating	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Hygiene	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Mobility in home	☐	☐	☐	☐
Mobility out of home	☐	☐	☐	☐
Positioning	☐	☐	☐	☐
Transferring	☐	☐	☐	☐
Communicating	☐	☐	☐	☐

How have the changes in the member's condition impacted the member's service needs?

Additional types of services Type: _____

Fewer types of services Eliminate: _____

Increased frequency Increase: _____ to _____

Decreased frequency Decrease: _____ to _____

Have there been any increases or decreases in the availability of the member's natural supports?

Additional supports Type: _____

Fewer supports Eliminate: _____

Increased frequency Increase: _____ to _____

Decreased frequency Decrease: _____ to _____

Are there areas member has expressed interest in and could benefit from services not currently in place? _____

Risk Factors	Yes	No	Unknown
Is the member at risk of choking or other problems when eating?	☐	☐	☐
Is the member's health at risk due to poor nutrition (e.g., eating disorder, refusal to eat, inability to afford nutritious food, etc.)?	☐	☐	☐
Would member's health be at risk if a paid provider or natural support person did not show up to provide scheduled services?	☐	☐	☐

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Instrumental Activities of Daily Living (not required for children)

	↑	↓	⇆	✕
Preparing meals	☐	☐	☐	☐
Shopping	☐	☐	☐	☐
Transportation	☐	☐	☐	☐
Managing medications	☐	☐	☐	☐
Housework	☐	☐	☐	☐
Managing money	☐	☐	☐	☐
Telephone use	☐	☐	☐	☐
Employment	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

How have the changes in the member's condition impacted the member's service needs?

Additional types of services — Type: _____

Fewer types of services — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Have there been any increases or decreases in the availability of the member's natural supports?

Additional supports — Type: _____

Fewer supports — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Risk Factors	Yes	No	Unknown
Is the member without means of communication (e.g., no phone or PERS)?	☐	☐	☐
Is the member unable to respond to emergencies independently? *	☐	☐	☐

* If member is never alone, check here for N/A: ☐

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Cognitive Function and Memory/Learning

	↑	↓	⇆	✕
Cognitive function	☐	☐	☐	☐
Judgment/decision-making	☐	☐	☐	☐
Memory/learning	☐	☐	☐	☐
Behavior concerns	☐	☐	☐	☐

How have the changes in the member's condition impacted the member's service needs?

Additional types of services — Type: _____

Fewer types of services — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Have there been any increases or decreases in the availability of the member's natural supports?

Additional supports — Type: _____

Fewer supports — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Risk Factors	Yes	No	Unknown
Does the member need to be supervised at all times?	☐	☐	☐

Notes:

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Behavior Concerns

	↑	↓	⇆	✕
Injurious	☐	☐	☐	☐
Destructive	☐	☐	☐	☐
Socially Offensive	☐	☐	☐	☐
Other Serious	☐	☐	☐	☐

How have the changes in the member's condition impacted the member's service needs?

Additional types of services — Type: _____

Fewer types of services — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Have there been any increases or decreases in the availability of the member's natural supports?

Additional supports — Type: _____

Fewer supports — Eliminate: _____

Increased frequency — Increase: _____ to _____

Decreased frequency — Decrease: _____ to _____

Risk Factors	Yes	No	Unknown
Has the member refused or spit out medications?	☐	☐	☐
Has the member misused prescription or OTC medications (e.g., taken too many at once)?	☐	☐	☐
Has the member ingested foreign objects or been diagnosed with PICA?	☐	☐	☐
Has alcohol or substance use caused the member any problems?	☐	☐	☐
Has the member left or attempted to leave home or other supervised activities without permission or when it would be unsafe to do so?	☐	☐	☐
Is the member non-compliant with medical appointments or treatments?	☐	☐	☐

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Additional Information

Yes	No	
☐	☐	Does member currently receive any skilled services (if Yes, check all that apply)?

- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Speech therapy
- ☐ Tube feedings
- ☐ Tracheostomy care
- ☐ Ostomy care
- ☐ Wound care
- ☐ IV therapies
- ☐ Catheter care

If yes, has the need for these services changed?

	↑	↓	⇆	✖	
Skilled needs	☐	☐	☐	☐	List other skilled needs: _____

Describe any other changes in member's condition(s) that may impact the member's service need. _____

Risk Factors	Yes	No	Unknown	
	☐	☐	☐	Is there any evidence of neglect by a caregiver?
	☐	☐	☐	Is there any evidence of self-neglect?

Notes:

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